**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO CLEVELAND CLINIC**



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1. Patient Information:** |  |  |  |  |
| Name *(First, Middle, Last)* | Cleveland Clinic Medical Record # if known: |
|  |  |  |  |  |  |
| Current Address | City |  | State | Zip |
|  |  |  |  |
| Last 4 Digits of Social Security # | Email | Phone Number | Date of Birth |
|  |  | ( | ) | / | / |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **2.** | **Release Information From:** |  |  |  |  | **3. Release Information To: CLEVELAND CLINIC** |
| Facility/Provider: |  |  |  | Name of Recipient: |  |  |  |  |
|  |  |  |  |  |  |  | Facility and/or Mail Code: |  |  |  |  |
| Address |  | City/State |  | Zip |  | Address | City/State | Zip |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Phone Number |  |  |  | Phone Number | Fax Number |  |  |
| ( | ) |  |  |  |  |  | ( | ) |  |  | ( | ) |  |  |
|  |  |  |  |  |  |  | Select one:PaperSecure electronic delivery (If secure |
|  |  |  |  |  |  |  | delivery, provide email): |  |  |  |  |
| **Purpose for Disclosure:Continuity of Care** | **Other (please indicate)** |  |  |  |  |  |
|  |  | (Purpose for disclosure must be completed prior to processing.) |  |  |  |  |
| **Dates of service to release (FROM):** |  |  |  |  |  | **(TO):** |  |  |  |  |
| Office Visits |  | History & Physical |  |  |  |  |  |  |  |  |  |
| Emergency Department Reports | Other |  |  |  |  |  |  |  |  |  |  |
| Discharge Summary |  |  |  |  |  |  |  |  |  |  |  |
| Operative Reports |  |  |  |  |  |  |  |  |  |  |  |

I, the undersigned, authorize the above named sending Facility/Provider as described in Section 2 to release health information as indicated/described above. I understand and acknowledge that the requested health information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. **This** **authorization does not include permission to release outpatient Psychotherapy Notes as defined below.\* Release of Psychotherapy Notes requires a separate authorization.**

**This authorization and consent will expire one year from the date of authorization written below**, unless revoked by me (or my legalrepresentative) through written notice presented to above named Facility/Provider as described in Section 2. Any revocation will not apply to information that has already been released in response to this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether or not I sign this authorization.

I understand that the sender of my health information may charge for the service of disclosing medical information and I am responsible for inquiring about these potential charges.

**If Authorization is not complete, signed and dated, it may be returned and result in my information not being released until completed.**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | / |  |  |  | / |  | / |  |
| *Signature of Patient/Patient’s Personal Representative* |  | *Printed Name* |  | *Date Signed* |

*Relationship, if not Patient*

*\*Psychotherapy Notes are defined as notes that document private, joint, group, or family counseling sessions that are separated from the rest of a patient’s medical records.*

***Submit completed request to the Cleveland Clinic Facility/Mailcode identified in Section 3 above.***

*NOTICE: If you send health information to Cleveland Clinic via email, please know that your message may be sent in an unencrypted email. An unencrypted email means there is a risk that the information in the email and any attachments could potentially be read by a third party when it is sent through the internet.*

Revision: 12/2016